In the Matter of the Application regarding the Conversion and Acquisition of
Premera Blue Cross and Its Affiliates
Washington State Insurance Commissioner's Docket # G02-45

ANTITRUST REVIEW
BY THE
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Report of Keith Leffler, Ph.D

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PREMERA CONVERSION ANTITRUST REVIEW
REPORT OF KEITH LEFFLER, Ph.D.

Executive Summary

The proposed conversion of Premera Blue Cross from a non-profit to a for-profit company is being reviewed under the Washington State Holding Company Act for Health Care Service Contractors and Health Maintenance Organizations (the "Holding Company Act").[1] According to this Act, one of the factors to be considered in evaluating the impact of the proposed conversion is whether the conversion will have an adverse impact on competition. The conversion does not directly affect in any way the number of competitors offering health insurance in Washington, and it, therefore, does not directly impact competition. However, in addition to considering adverse impacts on competition, under the Holding Company Act the Insurance Commissioner must also evaluate whether the proposed conversion may adversely impact the availability of health care coverage in Washington, whether the future business plans of Premera are unfair and unreasonable to subscribers and contrary to the public interest, and whether the conversion is likely to be prejudicial to the insurance-buying public.[2] If the proposed conversion were to result in lower provider reimbursements, this could reduce the participation in provider networks, causing deterioration in the availability of health care. If the proposed conversion were to result in higher insurance premiums, the insurance-buying public and the public interest would be adversely impacted.

The conversion of Premera to a for-profit status is expected to alter Premera's incentive regarding profit maximization; in particular, outside equity owners will likely expect Premera to set premiums and provider reimbursement levels in ways that maximize the value of Premera stock. The focus of this analysis is therefore on whether Premera has and will have the ability to raise prices to purchasers of health care insurance or to lower reimbursements to providers offering health care services to Premera's insureds.

The analysis begins by examining the regulatory constraints facing Premera. Insurers are required to file rates for Washington plans with the Washington Office of the Insurance Commissioner (OIC). Filed rates are subject to potential OIC disapproval under various rules. Most importantly, rates for individual and small group policies can only vary geographically based on provider price and efficiency differences. In contrast to premiums, provider reimbursements are not required to be filed with the OIC.

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[1] Chapter 48.31C RCW. The transaction may also be subject to the provisions of the Insurer Holding Company Act, RCW 48.31B, because Premera indirectly owns two life and disability carriers, States West Life Insurance Company and MSC Life Insurance Company. However, the pertinent provisions of the Insurer Company Holding Act appear to simply duplicate provisions of the Holding Company Act, so the analysis in this report is limited to the Holding Company Act.
[2] RCW 48.31C.030(5)(a)ii(C)(II) and (IV). The Insurer Holding Company Act includes parallel provisions. RCW 48.31B.015(4)(a)(iv) and (vi).

The market position of Premera in each county in Washington is then examined. The most significant finding, verifying the testimony provided by many members of the industry at public hearings, is the dominance of Premera in Eastern Washington. Premera's share of the insureds reporting to the OIC for individual, small and large plans for the year 2001, the most recent year for which reliable data was available, exceeds 80 percent in eight counties in Eastern Washington and it averages nearly 70 percent, while it exceeds 60 percent only in Pacific County in Western Washington and it averages under 30 percent.

Premera's high market shares in Eastern Washington suggest that Premera may have some control over market premium and reimbursement rates if competitors face impediments to entry and expansion. My analysis finds that there are some impediments to entry and expansion. Most important is consumers' and employers' inertia in switching health care providers and insurers. Employers indicate that they are very reluctant to switch insurance plans if their employees do not retain full access to the doctors that they are accustomed to seeing.[3] This implies that, to compete on an equal basis, an entrant must duplicate the provider network of any dominant seller. This can be quite costly to accomplish in the short run. In addition to buyer and employer inertia, an employer that switches health insurers faces administrative costs from dealing with employee concerns from a change and dealing with the different procedures of new insurers. The Blue Cross brand name and the legal constraint on Regence Blue Shield from directly competing under the Blue Shield name in most of Eastern Washington also provide some protection to Premera from entry and expansion by competitors.

When a seller dominates a market and when that market is protected by barriers to entry and expansion, the dominant seller is said to have market power, which is the ability to profitably charge prices above the competitive level. The analysis reported here suggests that Premera has such market power. However, the OIC rules and Premera's own procedures for setting of premiums appear to limit at this time the exercise of that market power in the pricing of its insurance.

Premera currently sets its premiums on individual policies on a statewide basis. Since the majority of Premera's business is in the relatively competitive I-5 corridor, its rates on individual policies appear to reflect that competition statewide. By OIC rule, premium levels on small group policies can vary by region only because of cost differences (unrelated to the experience of specific small groups.)[PROPRIETARY MATERIAL REDACTED]These rules and procedures appear to result in the competition of the major I-5 markets also currently constraining premiums for small and large groups throughout the state. Finally, larger groups are expected to have sufficient size to offset any Premera market power. Thus, I did not find

[3] This is based on confidential information.

any evidence that Premera is taking substantial advantage of any market power it may have in setting premiums at this time.

The analysis does support the existence of some market power and some exercise of that market power by Premera in setting reimbursement rates in areas where it has market dominance. Premera is able to set significantly lower reimbursements in Eastern Washington than other insurers that have smaller market shares. The data I have examined also suggests that the average claims paid to providers may be lower where Premera's market dominance is greater, though this evidence is mixed. In addition, I find that the extent of the discount on provider fees is greater where Premera market dominance is greater. Anecdotal evidence also suggests use of Premera market dominance in dealing with providers.

The analysis performed in this report is not intended to provide an answer to the question of whether the conversion of Premera to for-profit status may result in higher insurance prices or lower reimbursement rates, as that issue is being addressed by PricewaterhouseCoopers (PwC). Nonetheless, if Premera continues to compete statewide and if the OIC assures that the variance in individual and small group premiums result only from regional cost differences, then there is little reason to expect any change in the pricing of these policies. However, if Premera develops individual or small group policies that effectively cater to particular areas, it may be able to exploit its market power in setting provider reimbursements in ways that are not fully passed on in premiums, and thereby increase its profits. [

PROPRIETARY MATERIAL REDACTED

] However, any market power with respect to large groups is constrained by the possibility of self insurance and entry.

The analysis conducted herein indicates that Premera has some market power with respect to provider reimbursements in certain regions of Washington. While that market power may be fully exploited under the current regional reimbursement and contracting procedures, such procedures can be changed by Premera to more fully exploit its market power.

PREMERA CONVERSION ANTITRUST REVIEW
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Introduction

This investigation was initiated as a result of the application of Premera Blue Cross ("PBC"), LifeWise Health Plan of Washington, Calypso Healthcare Solutions, and their parent company, Premera, (collectively referred to as "Premera") to reorganize as for-profit entities. All four companies are currently organized as nonprofit corporations under Washington law. In addition PBC and LifeWise are licensed health care service contractors under chapter 48.44 RCW. The proposed conversion would result in a new for-profit corporation ("New Premera") acquiring Premera and its affiliates. Therefore the proposed conversion is subject to review under the Holding Company Act for Health Care Service Contractors and Health Maintenance Organizations (the "Holding Company Act").[4]

One of the provisions of the Holding Company Act requires that the transaction be investigated to determine whether it may have an adverse impact on competition. The Act requires a finding as to whether "there is substantial evidence that the effect of the acquisition may substantially lessen competition or tend to create a monopoly in the health coverage business."[5] Unless the Attorney General or a federal antitrust enforcement agency conducts this antitrust investigation, the investigation must be conducted by the Insurance Commissioner (hereinafter "OIC", an acronym for Office of Insurance Commissioner), with input from the Attorney General.[6] Here the antitrust investigation is being conducted by the Insurance Commissioner, with input and assistance from the Attorney General.

At a purely structural level, this proposed conversion does not appear to raise significant antitrust issues. The proposal would only convert Premera and its nonprofit affiliates to for-profit corporations. No competitor would be acquired

[4] Chapter 48.31C RCW. As stated above, the Insurer Holding Company Act may also apply. Chapter 48.31C RCW.
[5] RCW 48.31C.030(5)(a)(ii).
[6] *Id.*

in the proposed transaction, and no market share in any market would be increased. Thus the typical market effects of increased market power from an acquisition are not present.

However, serious competitive concerns about the proposed conversion have been raised in a series of public forums sponsored by the OIC and the Attorney General.[7] For example, in a forum held in Seattle on September 30, 2002, Len Eddinger, Director of Public Policy for the Washington State Medical Association, said that physicians are concerned that the conversion would cause their reimbursement rates to be reduced in areas like Eastern Washington, where "Premera is functionally a single payer." As a result, Eddinger said, the Medical Association House of Delegates voted unanimously to oppose the proposed conversion.[8] Another public forum was held in Richland on October 8, 2002. John Vornbrock, the Chief Financial Officer of the Yakima Valley Memorial Hospital spoke at that forum. He said: "We are concerned about how Premera will be able to compete in the consumer marketplace, provide a return for its shareholders, and also compensate providers in a fair and appropriate way in the future after the conversion."[9]

Barbara Flye was another speaker at the Seattle public forum. She is the Executive Director of Washington Citizen Action, a community-based organization having 50,000 members in Washington. She spoke of concerns that the conversion would produce higher health insurance premiums for citizens covered by Premera.[10] At a public forum held in Spokane on October 2, 2002, Frank Yuse expressed the same concern on behalf of the Senior Legislative Coalition of Eastern Washington.[11] Many other organizations and individuals have questioned whether the proposed conversion would have the effect of raising Premera's premiums and lowering its reimbursements to providers.

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[7] These public forums were held at Seattle, Spokane, Vancouver and Richland in the fall of 2002. Transcripts of the forums are posted on the Insurance Commissioner's web site: http://www.insurance.wa.gov/special/premera/PremeraTranscripts.asp.
[8] Transcript of the Seattle Public Forum at pp. 29-30.
[9] Transcript of the Richland Public Forum at pp. 34-35.
[10] Transcript of Seattle Public Forum at pp. 30-33.

Because of concerns like these, the Insurance Commissioner has allowed the Washington State Medical and Hospital Associations, Washington Citizen Action, and thirteen other Washington organizations to formally participate as interveners in the conversion proceeding.[12]

For the purpose of this analysis I will assume that conversion to for-profit status will create pressures on Premera to raise premiums and lower provider reimbursements. According to critics of the conversion, such pressures would arise from the need to increase profits to pay higher taxes as a for-profit corporation, and to meet the expectations of securities analysts and pay stock dividends. However, under basic economic principles, Premera could increase its prices or reduce its provider reimbursements only if it possesses market power as a seller of insurance or as a buyer of provider services.[13] As discussed in more detail below, market power is the power of a firm to profitably set prices above the competitive level.[14] If a seller lacking market power tries to raise its price to a non-competitive level, it will simply lose sales to competitors who continue to sell at the competitive price. Similarly, a buyer in a competitive market that tries to reduce the price that it pays to a non-competitive level will simply find that its sellers divert their sales to other buyers who continue to pay a competitive price.

These concerns raise issues under the Holding Company Act and under economic principles. Under the Holding Company Act the Insurance Commissioner must consider whether the proposed conversion will increase or prevent significant deterioration in the availability of health care coverage, whether the future business plans of Premera are unfair and unreasonable to subscribers and not in the public interest, and whether the conversion is likely to

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[11] Transcript of Spokane Public Forum at pp. 27-28.
[12] See Fourth Order: Ruling on Motions to Intervene, entered by the Insurance Commissioner on February 10, 2003.
[13] Market power on the selling side is also referred to as monopoly (one seller) power and on the buying side as monopsony (one seller) power.
[14] Market power is also equivalently defined as the ability to control prices and exclude competition. Since a seller that can exclude competition will be able to control prices, this aspect of market power is fully captured by the ability to profitably set prices above the competitive level.

be hazardous or prejudicial to the insurance-buying public.[15] Lower provider reimbursements could reduce participation in provider networks, increase deterioration in the availability of health care, and be contrary to the public interest. Higher premiums could be detrimental to the insurance-buying public and be contrary to the public interest.

Therefore, the issues investigated here are whether Premera has the power to control prices or exclude competitors, as (1) a buyer of health care services, or (2) a seller of health insurance. While having such market power is a necessary condition for the conversion to have any competitive impact, it is not a sufficient condition. If Premera has market power and has already exploited its market power in setting premium and reimbursement levels, it will be precluded from further anticompetitive premium increases or reimbursement rate decreases. Hence, even if Premera was found to have market power as a buyer or as a seller, but the power was fully exploited, post-conversion pressures on it to increase profits would have no effect.

Materials Reviewed

This investigation relied upon data received from Premera, Regence Blue Shield, First Choice, Group Health and the OIC. Premera provided data on the premiums collected and the claims paid for 2001 and 2002. The data was organized by county and by line of business. The Office of the Insurance Commissioner was the primary source of the market share data as provided on the "Form B" statements submitted by insurers which give the number of enrollees by county and by line of business.

In addition, more than 36,000 Premera documents and electronic data files that were requested by various members of the OIC Review Team were received. Some examples of categories of documents that were particularly useful were Premera's income statements for past periods and forecasts for future periods, by line of business; reports to Premera's board of directors and

[15] RCW 48.31C.030(5).

minutes of board meetings; studies prepared during the development of new products; rate filings and related material; provider fee schedules; underwriting manuals; market share data; brand studies; organization charts; and plan descriptions. As part of the investigation, more than 25 Premera executives and managers were interviewed.

The OIC was also a primary source of information and data. At the outset of the investigation the OIC gave the Review Team an overview of the regulatory environment for health carriers, including rate and other filing requirements and limitations, and network adequacy requirements, and a corporate history of Premera. Later the OIC provided an overview of structural changes to the Washington health insurance market, and an overview of behavioral issues.

An extensive program of field interviews of third parties was conducted and these interviews generated useful information. Confidentiality concerns preclude identification of the third parties, but the interviews included representatives of seven brokerage firms, nine competing health carriers, twelve hospitals and physician clinics, and four large employers that purchase of health insurance. Managers of the state Medicaid program and the Basic Health Plan were also interviewed. Overall more than 50 executives and managers participated in the third-party interviews.

Regulatory Constraints[16]

The market for health insurance in the State of Washington is regulated by the Office of the Insurance Commissioner. Insurance providers must file contract forms and rate schedules with the Insurance Commissioner prior to selling insurance in the state.[17] Insurance providers are not required to obtain OIC approval before implementing rate schedules, thus the rate filing process is

[16] This section is written with the assistance of the Antitrust Division of the Office of the Attorney General.
[17] RCW 48.44.070; WAC 284-43-920.

referred to as a "file and use" process.[18] However, filed rates for small and large[19] groups are subject to OIC disapproval, and carriers often file rates sufficiently in advance of their effective date that any issues about the rates can be worked out with the OIC before the rates take effect. Rates for group contracts are subject to the general power of the Commissioner to disapprove the contracts on the grounds that the benefits are unreasonable in relation to the amount charged under the contract.[20]

With regard to premiums for individual plans, the OIC may not disapprove or impede the implementation of filed rates.[21] However, rates for individual coverage are constrained by a statutory limitation on the loss ratio, which is the ratio between aggregate premiums and aggregate medical claims. If claims are less than 72 percent of premiums, the difference must be paid by the carrier to the state health insurance pool ("high risk pool").[22]

Under Washington law, health care insurers must provide certain benefit options. There are currently 22 benefit mandate statutes. Some of these laws require covering the services of certain types of providers.[23] Others require including specified types of service.[24] Also, there are statutes requiring coverage for persons under specified circumstances.[25] Individual health plans must also

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[18] Under the statutes governing the filing of rates for individual policies, the Commissioner is expressly prohibited from impeding the implementation of filed rates. RCW 48.44.017(4).
[19] Large groups can negotiate rates with carriers, and the OIC usually does not disapprove any negotiated rates.
[20] RCW 48.44.020(3); RCW 48.46.060(4).
[21] RCW 48.44.017(4).
[22] RCW 48.44.017(5) – (7).
[23] Osteopaths, RCW 48.44.023(1)(b); podiatrists RCW 48.44.225 and .300; registered nurses, RCW 48.44.290; chiropractors, RCW 48.44.310; home health care, RCW 48.44.320; denturist, RCW 48.44.500.
[24] For example, chemical dependency benefits, RCW 48.44.240 *et seq*,; diabetes benefits, RCW 48.44.315; mammograms, RCW 48.44.325; reconstructive breast surgery, RCW 48.44.330; mental health treatment, RCW 48.44.340; formulas for treatment of phenyketonuria, RCW 48.44.440; neurodevelopmental therapies, RCW 48.44.450; treatment of temporomandibular joint disorders, RCW 48.44.460.
[25] Continuation of coverage for dependent child with developmental or physical disability RCW 48.44.200, -.210; coverage to be available to person who loses eligibility for group coverage, RCW 48.44.360 *et seq.*; former family members to be covered after death or divorce of subscriber, RCW 48.44.400; adoptive children to be covered RCW 48.44.420.

cover maternity services and prescription drug benefits.[26] Policies that have the same coverage as the state's Basic Health Plan, and policies that are offered to employers with not more than 25 employees, may exclude most of the mandated benefits.[27] Employer-sponsored self-funded health plans are not subject to any of the mandated benefit laws.[28]

The state legislature was sufficiently concerned about the effect of mandated health benefits to require a special procedure for bills establishing mandates. Bills that would create new mandates must be submitted at least 90 days before the start of a session and are subjected to a statutory cost-benefit analysis.[29]

However, it is unclear whether mandated benefits have any significant effect on the cost or availability of health care insurance. Some mandates only require that an optional benefit be available at an additional premium.[30] Others simply require that if the services of a specified type of provider are covered, the services of an alternative type of provider must also be covered.[31] The impact of mandated benefits was one of numerous topics examined in a study published in April 2002 by the Consulting Team to a Washington State Planning Grant on Access to Health Insurance.[32] The Co-Principal Investigators of the Consulting Team are faculty members of the University of Washington Health Policy Analysis Program and the Rutgers University Center for State Health Policy.[33] This study concluded that "the research literature does not offer clear evidence

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[26] RCW 48.43.041.
[27] RCW 48.44.023(1)(b); RCW 48.46.066(1)(b).
[28] RCW 48.43.005(19)(i).
[29] RCW 48.47.020, -.030.
[30] Home health care, RCW 48.44.320; mental health treatment, RCW 48.44.340.
[31] A service provided by a registered nurse, or a denturist, must be covered if the nurse, or the denturist, is authorized by statute to provide the service and if the service would be covered if it were provided by a physician, or by a dentist. RCW 48.44.290 (registered nurse), -.500 (denturist).
[32] The studies published by the Consulting Team are available on the web site of the Washington Office of Financial Management, located at www.ofm.wa.gov/accesshealth/products.htm.
[33] The Consultant Team also included RAND, William M. Mercer Incorporated, and The Foundation for Health Care Quality.

on the likely effect of offering regulatory relief from mandates"[34] and that, "[b]enefit mandate relief is not likely to significantly reduce costs of insurance or increase coverage."[35]

Various other forms of statutory regulation in Washington can affect the health care insurance products and prices. Such regulatory provisions include guaranteed issue and continuity, adjusted community rating, limitations on age brackets and price differentials that may be used in rating, uniform eligibility requirements, and limitations on minimum participation requirements.

The purposes of these types of regulations are described in the *Market and Regulatory Study*:

> These regulations compensate for market forces that exclude or lead to higher premiums for high-risk persons. In competitive individual and small group coverage market without regulatory prohibitions to the contrary, insurers limit their risk exposure through risk-rated premiums, medical underwriting, waiting periods for coverage, and exclusion of pre-existing conditions. These practices tend to fragment rather than pool risk and lead to high premiums for or exclude from coverage entirely the sickest persons. Market regulations are intended to develop an inclusive market that provides affordable coverage to the people with the greatest needs.[36]

In all group coverage, small and large, carriers must provide coverage to all state residents who are within a group to which a plan is offered, and who are within the carrier's service area.[37] Further, all group plans must include a guarantee of the continuity of the coverage.[38] Renewal of coverage is subject to potential rate changes. For small groups, rate changes are subject to the rate constraints described below. In the area of individual coverage, all persons applying for policies must complete the statutory health questionnaire.[39] They

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[34] Washington State Planning Grant on Access to Health Insurance Deliverable 4.1.5, *Market and Regulatory Reforms to Expand Health Care Coverage*, at p.6 (April 2002)(hereinafter "*Market and Regulatory Study*").
[35] *Id.* At p. 12.
[36] *Market and Regulatory Study* at p. 2.
[37] RCW 48.43.035.
[38] *Id.*
[39] RCW 48.43.018.

must be accepted for coverage by the carrier if they reside in the carrier's service area, unless they qualify for coverage under the high risk pool based upon the results of the questionnaire.[40] The pool includes the top eight percent of health risks. Individual policies must include a guarantee of the continuity of the coverage.[41]

Other Washington regulations apply only to the individual and small group markets,[42] which are commonly referred to as the "regulated markets." Adjusted community rating is required in both individual and small group plans.[43] Adjusted community rates means that the rating method used to establish the premium for health plans must reflect only actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.[44] Under adjusted community rating, premiums to an individual or group can not be based upon the claims history of the person or group – i.e. the individual or group are not experience-rated. The risk pool for individual coverage includes all persons who purchase individual coverage from the carrier,[45] and the risk pool for small groups includes all persons in the carrier's small group plans.

Carriers may base rates on age brackets of at least five years, between ages twenty and sixty-five.[46] Individuals under age twenty are treated as twenty.[47] Carriers may develop separate rates for individuals age sixty-five or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer.[48] The highest rate for a group cannot exceed 375 percent of the lowest rate for a group.[49] Carriers must use uniform requirements in determining whether to provide coverage to all small employers

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[40] *Id.*
[41] RCW 48.43.038.
[42] The small group market includes employers having from one to fifty employees.
[43] RCW 48.44.022(1), RCW 48.44.023(3), RCW 48.46.064(1), RCW 48.46.066(3).
[44] RCW 48.43.005(1).
[45] RCW 48.44.022(2), RCW 48.46.064(2). RCW 48.44.023(3)(i), RCW 48.46.066(3)(i).
[46] RCW 48.44.022(1), RCW 48.44.023(3), RCW 48.46.064(1), RCW 48.46.066(3).
[47] *Id.*
[48] *Id.*
[49] *Id.*

applying for coverage or receiving coverage from the carrier. Statutes also limit minimum participation levels that carriers may use. A carrier may require a minimum participation level of 100 percent of eligible employees working for groups with three or less employees, but may not require participation by more than seventy-five percent of eligible employees working for groups with more than three employees.[50] Carriers must offer coverage to all eligible employees of a small employer and their dependents; they may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.[51]

The authors of the *Market and Regulatory Study* found no evidence that the imposition of state enrollment or rating regulations either decreased or increased the cost of health care insurance. They did observe that such reforms did have the effect of stabilizing faltering markets and making affordable coverage available to high risk individuals and groups without serious adverse selection.[52] In addition, the rate regulations imposed by the OIC on individual and small group plans will have the effect, if followed, of limiting the regional variations in premiums to equal cost differences. This implies that the rate regulations will limit the ability of an insurer to capture any savings in costs from control of provider reimbursements that might be obtained from market power in the purchase of health care provider services.

Does Premera have Market Power?

The issue of concern to this analysis is whether Premera has the ability to exercise market power. Market power is the power of a firm to profitably charge prices above the competitive level, or, on the buying side, the power of firm to

[50] RCW 48.44.023(5)(b); RCW48.46.066(5)(B); minimum participation requirements are used by carriers to protect themselves from adverse selection, in which only high-risk members of a group purchase coverage.
[51] RCW 48.44.023(6); RCW48.46.066(6).
[52] *Market and Regulatory Study* at pp. 12-13.

profitably pay below competitive prices.[53] The market power at issue concerns whether Premera has or can profitably charge above competitive premiums to its insureds or profitably offer below competitive reimbursements to health care providers in the state of Washington. As discussed above, the conversion of Premera to for-profit status does not alter the market structure in any way. That is, the same competitors will be present in the market, and they will operate under the same regulatory constraints. However, the change in Premera's status from non-profit to for-profit can and likely would alter Premera's incentives. Currently under its non-profit status, any excess of revenue over expenses (including capital costs) are not captured by any owners or other well identified residual claimants. Therefore, Premera's incentive as a non-profit to maximize its profits through both revenue increases and cost decreases is muted compared to what is expected under for-profit operation.

The expectation that Premera will likely have different incentives as a consequence of the conversion does not imply that it will be able to change its premium levels or provider reimbursements. If the market for the provision of health care insurance in Washington is effectively competitive then Premera is constrained by its competitors to operate efficiently and competitively. Therefore,

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[53] See, for example, Carleton and Perloff, *Modern Industrial Organization*, at page 92 and Landes and Posner, *Market Power in Antitrust Cases*, 94 Harvard Law Review (1981) ("A simple economic meaning of the term 'market power' is the ability to set price above marginal cost." at 937.) See also NCAA v. Board of Regents 468 US 85, 108 n.38 ("As an economic matter, market power exists whenever prices can be raised above the levels that would be charged in a competitive market.") The courts have frequently defined market power as the ability "to control price or exclude competition." US v. du Pont 351 US 377 at 391 (1956). A seller can, of course, literally set any price they want though no sales may be made at many possible prices. Hence, the economic definition of market power emphasizes the profitability of prices above the competitive level. The ability of a seller to limit entry is usually a necessary condition to have market power but does not define market power. A seller could have market power simply because of its superior skill or unique access to low cost technologies or resources. In that case, it may not be able to limit entry even though entry may economically be limited at the most profitable price for the seller with such market power because of the higher costs of rivals. In a strict sense, a seller has some market power whenever it faces a demand elasticity that is less than infinite. A perfectly infinite demand curve describes what economists call perfect competition, however, "perfect competition, is rarely, if ever, encountered in the real world ... ." Carleton and Perloff, *Modern Industrial Organization*, at page 56. Hence, I am concerned here with whether Premera has substantial market power. *Image Technical Serv. v. Eastman Kodak Co.*, 125 F.3d 1195 (9th Cir. 1997) ("*Kodak*").

in this Report we focus on the issue of whether the evidence indicates that Premera is currently constrained by the discipline of competition such that any changes in its incentives because of the conversion are unlikely to aversely impact consumers or providers.

Economic Methods of Identifying Market Power.

The most direct method of determining whether a seller has exercised market power is to identify the competitive price and then compare that price with the price actually being charged. Of course the hurdle to such a direct approach is the identification of the competitive price. Sometimes the competitive price can be estimated from an alternative time period or region that is presumably competitive and otherwise comparable to market under study. This is known as a benchmark analysis where the presumably competitive period or region is used a competitive benchmark.

In many situations, an appropriate benchmark is not available or the benchmark analysis is not determinative. An indirect approach to examining the presence of market power through a study of the structure of the market is therefore useful. I shall first perform such structural analysis of the markets in which Premera operates.

Market Structure and Market Power.

Market structure refers to two characteristics of a market that can indicate whether a particular seller can likely exercise market power. The first characteristic examines whether the seller controls a sufficient amount of the market to possibly have the ability to control the price. The control over a market by a seller is typically measured by the market share of the seller. When a market is characterized by many sellers each with low market share, there is a strong economic presumption the competition will exist. With many sellers, each seller will not expect its output decisions to have significant impact on market prices since it will be a small part of the market. In the extreme case, "perfect

competition" will result, in which each seller will simply take as beyond its control the market price and each seller will therefore offer output as long as its cost is less than the price.

Even if a particular firm currently dominates a market, this does not imply that seller has market power. Other sellers that are relatively small or that are not presently in the market may be reasonable alternatives to the dominant firm if that firm attempts to set non-competitive prices. Hence, the second characteristic of significance to the likely competitive performance in a market concerns whether other sellers constrain the pricing power of any seller that currently dominates a market.[54] The likely impact of other firms in constraining a seller that currently dominates a market is analyzed through the study of barriers to entry. Barriers to entry (or expansion) are features of a market that make it difficult for firms with small or no current market share to quickly expand or enter and capture sales if the price rises above a competitive level. Barriers to entry that may be relevant to the Premera conversion include the costs to employers of switching carriers, the cost to an entrant of establishing an attractive network of providers, the costs of establishing a reputation comparable to that of Blue Cross/Blue Shield, and the legal requirements to market health insurance in the state of Washington.

Market Share Statistics

In measuring market share, a precedent step is to identify the set of products that are effective substitutes. The identification of the set of effective substitutes that must be included in evaluating the market share defines "the relevant economic market." The relevant economic market must include all products that buyers consider to be reasonable substitutes – that is alternatives that the buyers would turn to if the price of the product at issue was not competitive.[55] If

[54] The significance of other sellers in constraining a dominant seller is emphasized in *Image Technical Serv. v. Eastman Kodak Co.*, 125 F.3d 1195 (9th Cir. 1997) 1202.
[55] The courts have referred to this test as identifying all "products that have reasonable interchangeability." See, for example, *U.S. v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 394 (1956)

there are many close and good substitutes available to consumers then a seller will not have market power since any attempt to charge non-competitive prices will simply lead to losses of sales.[56]

The second aspect of the relevant economic market in defining market shares concern the geographic scope of the market. The relevant geographic market is the area of "effective competition."[57] The area of effective competition refers to the area in which buyers or sellers can reasonably find alternative sellers of the product at issue if one firm raises its price.

The Department of Justice/Federal Trade Commission Merger Guidelines provide a concise description of what is a properly defined relevant economic market: "a market is defined as a product or group of products and a geographic area in which it is sold such that a hypothetical profit-maximizing firm ... that was the only present and future producer or seller of those products in that area likely would impose at least a 'small but significant and nontransitory" increase in price." (At §1.0.) In essence, this conceptual definition simply means that a relevant market must include all products that are considered reasonable alternatives by consumers. Otherwise, "a hypothetical profit-maximizing firm that was the only present and future producer or seller" of some product would not be able to profitably increase price because its buyers would, in reaction, switch to the alternatives.[58]

In this Report, the interest is in whether Premera has the ability to charge above competitive premiums for health insurance or pay below competitive provider reimbursements. I have reached the opinion that there are relevant economic markets for the sale of health care insurance to particular groups, including individuals, the employees and dependents of small employers, and the

[56] For simplicity, I couch the analysis is terms of selling a product. Nothing changes when looking at market power and the definition of the market on the buying side.
[57] *U.S. v. Grinnell Corp., 384 U.S. 563,575-76 (1966).*
[58] Since a low market share implies the absence of market power, the definition of the relevant market is often highly contested. If a relatively broad and inclusive set of products is included, the measured market share will be relatively low, and as a consequence it may appear that no seller has market power.

employees and dependents of large employers, in the state of Washington.[59] One issue in this market definition concerns self insurance. For individuals and small groups, self insurance implies large and unacceptable risks such that for these plans a significant percentage of potential buyers are unlikely to react to above competitive insurance prices by foregoing insurance.[60] However, for large employers, the large pool of employees implies that self insurance can be an effective alternative to commercial insurance. Many large employers in Washington do self insure using third parties for provider networks, claims administration and processing. For large employers, such self insurance belongs in the relevant product market. The OIC data relied on here includes only those self-insured employers that use a Third Party Administrator that reports to the OIC. I know of no way to accurately determine the number of unreported insured covered under non-reported self-insured plans.

A second issue relevant to the proper product market definition concerns health maintenance organizations such as Group Health that integrate the provision of medical care with the provision of insurance. It seems clear that such integrated plans are reasonable alternatives to more traditional health insurance and that such plans belong in the relevant product market.[61]

The geographic market is clearly no broader than the state since an insurer must be authorized by the OIC to sell health insurance in this state.[62] I have also reached the opinion that there is a relevant economic market for the

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[59] This market definition implies that that if there were only one health care insurer offering insurance to particular groups, that insurer could raise prices above a competitive level. This would seem non-controversial. If I were attempting to directly measure market power I would identify the competitive level of the prices as those that would exist when there are a number of alternative providers trying to attract the patronage of employers or individuals. Alternatively, under competition prices are expected to be at a level that just compensates sellers for their costs including a normal rate of return on invested capital.

[60] In *Reazin v. Blue Cross & Blue Shield of Kansas*, 899 F.2d 951 (10th Cir. 1990) the Supreme Court concluded that the jury could properly exclude self-insurance from the third-party health insurance market.

[61] In *Blue Cross & Blue Shield of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995).

[62] For self insurance by large employers, third party providers of processing and administration that are not in the state of Washington belong in the relevant economic market but they do not report to the OIC.

purchase of provider services on a local basis within in the state of Washington. The exact definition of a "local basis" is problematic, but generally I intend local basis to imply metropolitan areas.[63] In considering the relevant geographic market on the buyer side, the question concerns insurer reductions in reimbursement below the competitive level. Hence how patients might react to above competitive prices in one geographic area is not of relevance.[64] On the provider side, the major suppliers, physicians and hospitals, typically have substantial investments that are both product and location specific. While it is conceptually possible for a physician to change occupations or locations in response to a reduction in reimbursement, such a response is not expected from a 'small but significant and nontransitory reduction in reimbursement. Similarly, while a hospital could be converted to other uses, that reaction is certainly not the expected response to a 'small but significant and nontransitory' reduction in reimbursement.[65]

For a buyer of health insurance, the desire to deal with local providers of health care services will imply that only insurers active in the local market will be reasonable alternatives. Therefore, there will also be a "local" relevant economic market for the buying and selling of insurance services.

Measuring Market Share.

Market shares can be measured according to revenues or units. If a more expensive product can effectively substitute for multiple less expensive products then a revenue measure of market share will more accurately reflect the relative

[63] The metropolitan areas in Washington approximately correspond to counties. The clear exceptions in Eastern Washington, which will be the geographical focus of possible Premera market power, include the Wenatchee area (Chelan and Douglas counties) and the Tri-Cities area (Benton and Franklin counties.)

[64] If the question of issue was the ability of providers to exercise market power, the preferences of patients for local versus out-of-the-area care would be relevant.

[65] As also discussed below, there is a more narrow relevant economic market for the purchase of insured services that are not Medicaid or Medicare insured. This separate market exists because there are different reimbursements rates for the government insureds. See §1.12 of the Merger Guidelines Product Market Definition in the Presence of Price Discrimination. ("The Agency will consider additional relevant product markets consisting of a particular use or uses by groups of

positions of the sellers. For example, a more expensive copier may be a more durable machine that will simply produce more copies over time before being replaced. In that case the more expensive copier is effectively a multiple of the cheaper copiers and a revenue based market share will better reflect the relative sales of sellers compared to a unit based market share. In contrast, if a more expensive product is simply one with more features, for example, a copier with a touch pad digital display instead of dials, a unit based market share will be preferred.

For health insurance, differences in the premium cost among policies and insurers typically reflect greater expected risks and coverage. Each potential customer buys at most only one policy. By selling a policy to a family, a health insurer controls the expected demand for health care by those insureds.[66] Hence an insurer's relative position in the market place should be well approximated by its share of the individuals that it insures.

Market Shares Based on Number of Covered Individuals

I report in Tables 1-A - 1-D the percent of the total number of insured individuals included in the OIC Form B data for 2001 that are insured by five largest insurers for individual plans, small group plans, large group plans, and combined plans, that is, these three plan types together.[67] The five largest

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buyers of the product for which a hypothetical monopolist would profitably and separately impose at least a 'small but significant and nontransitory' increase in price.")

[66] Of course, a married couple may have overlapping coverage from two employers.

[67] The data presented in Table 1 includes individuals insured by Cigna, PacifiCare and the Uniform Medical Plan each of whom does not report to the OIC. Data from these three plans were obtained directly. The data excludes individuals insured under self insured plans using an administrator that is not required to report to the OIC since I do not have any data on these plans. In the interviews with Premera, brokers and other carriers, the consensus is that there are a significant number of such individuals working at employers with over 100 employees. Therefore the market shares for large plans are likely biased upward. In addition, the data excludes insured individuals that are insured by plans not reporting to the OIC. This is particularly likely for individuals living in Washington but employed out of the state of Washington. Mainly this should impact counties neighboring Portland, and especially Clark County where Regence Blue Shield Blue Cross of Oregon retains the exclusive rights to market under the Blue brand. In addition, Regence Blue Shield of Idaho markets under the Blue Shield brand in Asotin and Garfield counties. "All Plans" simply aggregate together the individual, small group, large group plans. In

insurers in each plan category include Premera, Regence, Group Health, and Aetna. For individual and small plans, KPS is included. For large plans and combined plans, First Choice is included. The share data are broken out separately by county.[68] Tables 1-A - D also show the overall shares for Western and for Eastern Washington.[69]

As shown in Tables 1, Premera appears to dominate the supply of insurance in some segments of the health insurance market in a number of counties in Eastern Washington. For individual plans, in 2001 Premera provided about 81 percent of coverage in Eastern Washington with a share as high as 99.5% of the members in individual plans in Douglas County. For small group plans, Premera share in Eastern Washington is over 87%. For large group plans reported in the OIC data, Premera's share of 63% is substantial. Overall, for individual, small and large group plans, Premera's share in Eastern Washington is about 69%. In contrast to Premera's high market shares for these plans in most of Eastern Washington, the data suggests that Premera generally faced significant competition in Western Washington in the sale of individual, small and large plan health insurance. Indeed, Regence is a more significant insurer in

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addition to relevant markets for the sale of health insurance to individuals, small groups, and large groups, there are also relevant economic markets for government provided health insurance, for federal employees, and for state subsidized Basic Health insurance. These markets are not at issue concerning any Premera market power with respect to the sale of health insurance.

[68] The Appendix provides the details as to the source and assembly of the data. The small groups are employer covering groups with 1-50 employees. The large groups cover 51 plus employees, federal employees and those under PEBB plans. As used here, large groups include what some insurers refer to as Mega groups, groups with 100 plus employees. The single category, large groups, is used here because of data limitations.

[69] I also examined OIC Form B data for 2002. However, I concluded that the data was not reliable. The OIC changed the reporting requirements for 2002 allowing the filers to aggregate various plans together. The OIC allowed insurers to include the Basic Health Plan and the Healthy Options Plan in the large group category. Such inclusion is not appropriate in measuring Premera's position in the sale of health insurance to large employers. In addition, Group Health incorrectly included those individuals insured under the Basic Health Plan and the Healthy Options Plan in the individual plan numbers. Premera's Form B numbers for 2002 are also apparently inaccurate. For example, for individual plans, Premera's OIC Form B reports 99,969 insureds while data supplied to me from Premera reports only 21,621 members. In the small group category, the Form data shows 131,062 members while Premera's data shows nearly three times this. As an example of the unreliability of the Premera Form B data, Premera's small group

Western Washington than Premera, with Regence covering about 35% of the reported insureds to Premera's 27% in 2001.

Regardless of the particular market share, the data suggest the possibility that in Eastern Washington, Premera may be able to exercise some power over insurance premiums offered to employers because of relatively limited choices available to the buyers. In public hearings, Premera has been described as a "single payer" in Eastern Washington. However, generally in Western Washington, and in particular in the major population center of Snohomish-King-Pierce-Thurston counties, Premera is not a dominant player. Indeed, in Western Washington. Regence is the largest insurer though neither Regence nor Premera is dominant based on typical economic measures. Therefore, on a priori grounds, there is no expectation that Premera has any ability to control premium levels or provider reimbursements in Western Washington.

Market Shares Relevant to Purchasing Health Care Services

The market shares given in Tables 1 indicate Premera's market position in dealing with individuals and employers seeking to purchase health insurance within one of the plan segments. These market shares do indicate Premera's position among the OIC reported patients that are expected to pay the providers "fee for service" or "PPO level" reimbursement rates. However, these shares do not indicate the total share of insured patients controlled by Premera since the figures exclude individuals that are in the Basic Health Plan and private Medicare or Medicaid plans, non-reported employer self insured plans, or that are insured under an out-of-state plan. In addition, the market share figures in Table 1 include people that are insured under a Group Health Staff model plan. These people generally do not purchase health care in the same market in which Premera contracts with providers.

Table 2 gives some alternative calculations of Premera market position. The percentages in Table 2 first report the percentage of all insured OIC reported

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members for Skamania County are reported as 22,551. This, however, is more than double the

individuals that are administered by or insured by Premera. This adds the Medicare, Medicaid, Basic Health, and Administrative Service Contract plans to the individual, small and large plans of Table 1.[70] Premera's percentage in 2001 of all OIC reported insureds is 54% in Eastern Washington and 24% in Western Washington. This reduction in Premera's shares is the result of the significance of Community Health Plan of Washington and Molina in the Basic Health Plans.[71] Table 2 also reports the percent of the population in each county that are insured by some Premera plan.

The percentages reported in Table 2 are not, however, indicative of Premera's market position in purchasing health care services. Individuals covered under Medicare, Medicaid and the Basic Health Plan typically offer reimbursement levels that are substantially below "fee for service level," or the "PPO level." The "PPO level" is generally discounted from the "fee for service level," but it is usually much higher in Washington than fees under the governmental programs. The market share figures given in Table 1-D are therefore most indicative of Premera's control over "profitable patients."[72] When Premera offers a contract or negotiates with providers, it is the potential loss of these profitable patients that will be of concern to the providers. Therefore having a substantial share of these patients may give an insurer the ability to

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total population of the country.

[70] These shares continue to exclude any non-reporting self-insureds, and insureds that are covered by out-of-state non-reporting insurance plans.

[71] These Plans cover 60% of those insured under Basic Health as compared to Premera's 20%.

[72] The market shares in Tables 1 exclude from the denominator individuals that are covered under out-of-state plans and self-insured plans that do not report to the OIC. Ideally this data would be included. I have attempted to run a rough check on the data in Table 1-D by calculating a proxy for the number of "profitable" private insureds in a county. This calculation subtracts from the county population the number of Medicare and Medicaid eligible, military, and an estimate of the number of uninsured. The Appendix describes the sources of data. Premera's percentage of this estimate is generally closely related to the market share figures in Table 1-D. The major exceptions are for the four counties north of the Portland area, Clark, Cowlitz, Klickitat and Skamania, and for Asotin County. The differences for the Portland area counties are likely due to persons living in these counties but employed and insured by non-reporting Oregon employers. For Asotin County, the difference is likely due to Idaho Blue Shield which offers coverage in that county. See http://www.id.regence.com/needCoverage/individual/. For the purposes of evaluating market power from the market shares figures, the market shares for these five counties should be adjusted downward.

negotiate below market prices; that is, the insurer may have market power in the purchase of provider services.

Barriers to Entry and Expansion

A low market share is sufficient to conclude that an individual seller does not have the ability to charge prices significantly above the competitive level – that is, does not have market power. However, a high market share alone does not indicate whether the seller has market power. For example, one very effective way for a seller to achieve a dominant or even a "monopoly" position in a market is by charging a low price for a high quality product. If, however, a seller currently has a dominant position in a market, as does Premera in the sale of insurance in Eastern Washington, that seller would be able to exercise market power if other sellers could not quickly, and at relatively constant cost, expand output. In this situation, the consumers currently purchasing from the dominant seller would have nowhere to turn if confronted with an above competitive price. Economically, the constraints that might limit the output expansion of non-dominant sellers are referred to as barriers to entry if those sellers are currently not in the market and as barriers to expansion if they are already in the market. For simplicity, I shall refer to both as barriers to entry.

The economic analysis of barriers to entry focuses on non-recoverable expenditures that a seller incurs to serve new customers. An entrant into a market incurs such costs only with the expectation that the price after entry will be sufficient to allow recovery of such sunk cost. A seller not currently operating in a market may observe a current price that is above the competitive level and hence sufficient to allow recovery of any competitive entry costs. However, that observation is not relevant to the entry decision since the entrant will typically expect a reaction by any dominant firm, such that it is the expected price after entry that is relevant.

In markets where there are many sellers, barriers to entry are typically limited to costs that entrant must incur that were not incurred by incumbent firms. This is because the equilibrium competitive price will include an amount

compensating the sellers for any entry costs. A potential entrant into a market with many firms will not expect the price to change in any significant way as a consequence of the entry. Hence, the entry costs incurred by the incumbents will not impair entry if prices rise above the competitive level. However, if a market is currently dominated by a seller, an entrant can anticipate a significant price reaction to entry. Hence, the entrant must be concerned with the possibility that the price, upon entry, will fall as low as the incumbent's average variable cost – which is less than the entrant's average variable costs since the entry cost is variable to the entrant but sunk for the incumbent.

The typical analysis of barriers to entry focuses on the capital costs of entry. For example, there are substantial barriers to entry into petroleum refining. A new entrant must permit and build a refinery at an expense of hundreds of millions of dollars. The physical asset that results is specific to petroleum refining and the investment is not recoverable outside of petroleum refining. If upon entry the price of refined product falls, there is no reasonable alternative use for the assets.[73]

The capital costs of entry are relatively minimal for the health insurance business as no substantial industry and location specific assets are required. While an entrant requires an infrastructure to handle customer and provider relations, collections and payments, such infrastructure will largely consist of variable costs with little non-recoverable costs if the entry is not successful.

However, the market for health insurance does have some characteristics unlike traditional manufacturing type businesses. Most importantly, health insurance is ultimately used to pay for expenses of care decided by patients' physicians. Most individuals have established relationships with their primary care physicians, and for those individuals with chronic conditions, most have established relationships with specialists. Employers attempting to switch health

[73] Contrast petroleum refining to the self storage business. In the self storage business a seller must obtain permits and erect a building at considerable expense. However, the resulting asset is not specific to self storage. That is, at minimal expense the building could be converted to

insurers will face great resistance if the plan does not include the employees' and their dependents' traditional providers. This necessitates that an effective potential entrant -- effective in the sense of being able to constrain the pricing of a dominant insurer -- will require a broad and inclusive network of physician providers. Setting up such a network can take time and involve non-trivial and non-recoverable expense.

One empirical measure of the extent of any barrier to entry because of the scale of the provider network required for effective entry is available from fees charged to gain access to the existing First Choice Network. This Network was formed by physicians and hospitals. The Network is made available to health insurers for a fee that I am informed is about $3 per member per month.[74] This represents about one to two percent of the typical cost of health insurance per member. Therefore I conclude that the cost of gaining access to a network of providers is itself not a significant barrier to entry. However, as discussed further below, the reimbursement rates under the First Choice network are significantly higher than for Premera in Eastern Washington, such that utilization of the First Choice network is not an economical entry avenue.

The cost to an employer of switching from a product currently utilized can itself be a barrier to entry. For example, one of the barriers to entry into the operating system market noted in the case against Microsoft was the "switching costs" to consumers of learning a new system and replacing their Windows applications. For an employer, switching health insurance providers will generate significant switching costs of learning new administrative systems and dealing with employee concerns, in addition to facing the uncertainty of the longevity of a new insurer. In our interviews, purchasers, brokers and insurers agreed that it would take about a five percent expected savings to motivate an employer to switch from a satisfactory current health insurance provider.

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office space or perhaps light manufacturing. It is only the capital asset investment that is specific to the particular industry under consideration that can constitute a barrier to entry.

[74] Interview with First Choice. [PROPRIETARY MATERIAL REDACTED]

Another barrier to entry results from Premera's operation as a licensee of the Blue Cross Blue Shield system. This gives Premera customers use of the Blue Card which provides access to Blue networks out of the Premera service area. A number of purchasers considered this an important advantage given the mobility of today's population. In Western Washington and selected counties in Eastern Washington, Regence is a licensee of Blue Cross and thus offers exactly the same out of area advantages as Premera. However, in the remainder of Eastern Washington, Premera retains the Blue Shield license that it acquired in the merger with MSC. This prevents Regence from utilizing the Regence name, Blue Shield trademark, or the Blue Card in its marketing in most of Eastern Washington. While other national insurers such as Cigna or Aetna can also offer out-of-area networks, smaller and regional insurers will be unable to offer this benefit in competing with Premera. Hence the Blue Cross Blue Shield license represents a barrier to entry.

In addition, the reputation and brand familiarity of Blue Cross offer Premera some protection from competition. According to Premera, "(r)esearch indicates that for health insurance brands, market share is a significant driver of purchase interest."[75] Hence, a high market share can itself be a barrier to entry.

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As implicit above, a barrier to entry is fundamentally any economic factor that allows a dominant seller to price above the competitive level without attracting entry. An issue that has not been addressed that may be of particular significance to Premera is the definition of the competitive price. Fundamentally a competitive price (the price that would exist with substantial competition) is a price that allows an efficiently operating firm to recover all its costs including its opportunity costs of capital. In the health insurance market the most significant cost by far is the cost of paying the providers of the insured health care services. The provider reimbursement costs typically represent 80 percent or more of the total costs. Unlike most markets, a dominant seller of health insurer in a region is likely to be able to exercise market power on the buying side and thereby reduce its costs.[80] Therefore, even if there are no traditional barriers to entry into the sale of insurance, entrants into the market will only be able to constrain the price to a level that reflects their likely higher provider cost rather than the cost of a dominant incumbent. Thus, Premera's high market share and any resulting ability to control prices on the buying side can act as a barrier to entry at prices above those that are profitable for Premera.

Absent barriers to entry, a dominant seller will not be able to charge prices that are higher than the costs of the potential entrants, and, by definition, prices equal to those entrant costs are the "competitive prices". However, this does not imply that a dominant seller that can impact its buying costs will be constrained to set prices that are equal <u>its</u> costs. In this situation, exploitation of market power on the buying side by a dominant insurer would not result in any <u>short run</u>

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[80] Contrast the health insurance market with, for example, the soft drink market. Even if Coca Cola "monopolized" the soft drink market it would be unlikely to have any market power in the

adverse impacts on employers and consumers. However, in the longer run, below competitive reimbursements by a dominant seller could result in adverse quality effects as providers relocated or choose other locations where such dominance did not suppress reimbursements. Such long run concerns were frequently mentioned in interviews with provider organizations.

Pricing Rules and the Expected Constraints on Exercise of Market Power

As discussed above, the Office of the Insurance Commissioner requires that state wide risk pools be used for pricing of health insurance policies to individual and to small groups. However, the OIC does allow geographical variance in rates based on overall provider cost and efficiency variations that are not specific to particular groups or plans. The market share data discussed above suggests that Premera generally faces effective competition in Western Washington. Western Washington accounts for over 75% of the state's population. Therefore, assuming the OIC rules concerning geographical variance in rates for individual and small group plans are effectively enforced, Premera is expected to be constrained by the competition it faces in the major Western Washington market from charging higher premiums compared to costs to customers in other areas where it may not face substantial competition.[81]

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sugar market, the bottle market, or the labor market as it competes with many other industries for inputs that are not industry specific.

[81] In effect, the OIC regulations prevent Premera from directly price discriminating on a geographical basis in the insurance markets where it faces less competition. However, the OIC regulations do not preclude the design of specific plans tailored to one area versus another that might in effect allow such discrimination.

Unlike policy premiums, there are no OIC rules limiting Premera's ability to negotiate favorable provider rates in regions where it can use its control of a substantial percent of the insured patients as bargaining leverage. There are also no reporting requirements concerning provider reimbursements. In addition, OIC has no regulations requiring Premera to pass-on any cost savings via area adjustments.

Market Power and Premera's Revenues, Claims and Reimbursements

As discussed, under the Washington regulatory environment and Premera's premium setting procedures which link premiums to costs, it is not likely that there will be any significant variation of premium levels as related to Premera market dominance. I collected data from Premera on the average premiums per member by county by plan type. The variations in the average premiums per member were far beyond what would possibly be explained by any differential market power. For example, the average premiums by county for individual policies in 2002 ranged from $107 in to $180, from $81 to $274 for small plans, and from $84 to $267 for large plans. There are two related explanations for these substantial variations. Most importantly, the data on premiums link to the locations of the employers rather than to that of the member insureds. That is, the numerator of revenue per member variable is the revenue by county of the employers, while the denominator is the number members in the county. Since many employees will live in different counties than where they are employed, the revenue per member variable will not accurately reflect the true cost of insurance in the counties. In addition, there can be variations in the average coverage of the plans across the counties which would cause the revenue per member to differ independent of any ability to control pricing. Therefore, the revenue per member data cannot be used to test the hypothesis that Premera has market power in setting rates.

While I unable to test empirically whether Premera has exercised any market power in setting its rates, Premera's recent projections of future revenues suggest that Premera is not completely constrained by competition in its rate

setting in Eastern Washington, where it has a dominant market share.

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Premera's pricing for renewed accounts also indicates the possible absence of effective market competition constraints on pricing in Eastern Washington.

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While the OIC rules and Premera's current and historical pricing procedures may be sufficient to eliminate substantial pricing variation based on market dominance, there are no such constraints on exercising market power with respect to provider reimbursements. I now examine whether there is evidence that Premera is able to negotiate more favorable provider reimbursements rates in the areas where it has a more dominant market share.

The most compelling evidence that Premera is able to use its dominant market share to pay lower reimbursements to providers is simply the level of the negotiated reimbursements. According to interviews with the leading competitors, First Choice and Regence, in Eastern Washington, Premera is able to negotiate a discount with the providers that is, on average, 8 to 10 percent below what the competitors can achieve.[86] I have verified this by comparing the actual reimbursement rates of Premera, Regence and First Choice in the

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[86] This is based on confidential information.

Spokane area.[87]

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The difference in reimbursement rates is clear evidence of Premera's ability to use its dominant position in the marketplace to negotiate more favorable rates than its major competitors.

I have also examined the contractual relationships between physicians and Premera. I hypothesize that physicians would be more likely to accept the Premera standard contract, which discounts from standard fees, in regions where Premera accounts for a greater percent of the patients. I obtained data from Premera as to the total number of physicians it had under contract in each county in Washington and the percent of those for which the agreement paid more than the standard reimbursement.

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[87] This is based on confidential information.

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[92] Data from Premera document with the Bates stamp 0035195. PROPRIETARY MATERIAL REDACTED

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I included factors for Premera's newest plans, the Dimensions plans, as well as the factors for Premera's older plans, which are labeled "PBC." The Dimensions Foundation and Heritage plans are PPO plans, and the Dimensions Global plan is a traditional plan. The PBC Prudent Buyer ("PB") is a PPO plan, and of course the PBC Traditional plan is a traditional indemnity plan.

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Regression Analysis of Reimbursements

I have also examined the extent to which the average amount per claim paid to various provider types is related to Premera's market dominance. At my request, Premera provided data on the number of claims and the reimbursement amounts for 2001 and 2002 for a number of categories including inpatient and outpatient hospital, OB-GYN, ophthalmology, orthopedic, primary care, and pediatric physicians by county.

Claims and reimbursement amounts will of course vary substantially simply because of the severity of the underlying illness or injury. I do not have

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information available that allows for control of the "severity" of the event initiating the claim. However, if there are a sufficiently large number of claims included for each county, variance across counties due to event severity should be minimized. In addition, I have no reason to expect differences in average reimbursements due to differences in event severity to be related in any way to Premera's share of the market. In order to minimize the impact of event severity, I have eliminated claim categories where there are not substantial numbers of claims for most of the counties examined. This left me with In-patient, Out-Patient, Primary Care Providers and OB-GYN claims.[94] The appendix Tables A-4 - 7 details the counties in Washington and indicates for Out-Patient Claims, Primary Care Provider Claims, and OB-Gyn Claims, the number of claims for the county, and also the counties that are excluded in the analysis because of a relatively small number of claims.[95]

The hypothesis to be tested is that the average contract claim amount in a county is negatively related to percent of patients that Premera controls in a county. If Premera is able to exercise market power against providers when it has a substantial market share, I expect a larger share to be associated with a lower average claim amount. The statistical procedure used to test the hypothesis is multiple regression analysis. Regression analysis is a widely accepted statistical tool frequently used by economists in both research and

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[94] Revenue data by county were not provided for individual plans for 2001. Therefore the variable revenue per member could not be calculated such that this plan and year is excluded from the analysis. In patient and hospital claims are not included because of the possible extremely large variations in claims that can occur because of a few unusual illnesses. Pharmacy, Pediatrics, Orthopedics, and Ophthalmology are excluded because of the large number of counties that had very few claims. Other is excluded because of the likely substantial variation across counties in what is included.

[95] In order to have enough observations to perform meaningful analysis, the minimum number of claims for inclusion varies by plan type and claims category. These minimums are shown in the appendix tables. In addition, some counties are excluded if the average claim amount indicates errors in data. These counties are also shown in the appendix tables.

litigation related studies. "Multiple regression analysis is a statistical tool for understanding the relationship between two or more variables."[96]

Alternative market shares are used. First, I use the Combined Plan share for 2001 from Table 1-D. This is Premera's share of the OIC reported individuals covered under individual, small or large plans.[97] This variable should proxy the dominance of Premera in controlling the preferred patients where the providers can expect reimbursements at PPO levels or higher. I also examined the impact of the All Plan market share from Table 2. This market share indicates Premera's overall control of insured individuals.[98]

The average coverage of a Premera policy within a county may vary substantially from county to county. This will, of course, directly impact the amounts claimed under the policies within the counties. In order to take into account of coverage variation, I included the average premium per member in the analysis.[99] This variable is intended to measure the extent of the coverage of the typical policy in the county. The expectation is that the greater the average premium, the greater the coverage and therefore the greater the expected claim amount. Hence a positive regression coefficient is expected. I also included the network adjustment factor for each county in the analysis. The network adjustment factor is included to take account of higher reimbursement rates and different provider efficiencies. Again a positive relationship between average

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[96] Daniel Rubinfeld, "Reference Guide to Multiple Regression," in *Reference Manual on Scientific Evidence,* Federal Judicial Center, 1994, page 419. Multiple regression simply refers to multiple variables being used to explain another variable. For example, a multiple regression analysis could be conducted to "explain" people's weight in which multiple "explanatory" variables might include height, waist size, and wrist size.

[97] The claims data is specific to plan type, individual, small or large. However, the market shares for the specific plan types are not relevant to Premera's ability to achieve large discounts from providers since reimbursement is not tailored to plan types. As discussed above, these market shares do not include any that are insured under individual, small or large plans by out-of-state non-reporting plans, and also under self-insured employer plans.

[98] These market shares also do not include any insured under individual, small or large plans by out-of-state non-reporting plans, and also under self-insured employer plans.

[99] As discussed above, I expect there to be substantial errors in variables in this data. However, I do not expect such errors to be correlated with the claims per member. Premera did not provide data on the breakdown by county of individual plan members for 2001. Therefore, the regressions for average claims for individual plans in 2001 do not include this variable.

claims amount and the network adjustment factor and a positive estimated regression coefficient is expected.[100]

The statistical results of the regression analyses are summarized in Table 4. The R squared statistic measures the success of the independent variables (market share, premium per member, and network adjustment factor) in explaining the average claim per member by county. The T statistic measures the statistical significance of the estimated coefficient on the market share variable. Generally, a T statistic above 1.0 indicates that the relationship between the market share variable and the average claims per member is not simply due to chance. The higher the T statistic, the greater is the statistical reliability of the indicated relationship. A T statistic of 2.0 or greater meets a 95% plus test of statistical reliability.

As a summary of the results, I find evidence that the average claims levels per member are lower where Premera controls a larger share of the patients. This is consistent with the hypothesis that Premera is more successful in negotiating discounts where it controls a greater proportion of the patients. For out-patient claims, the estimated coefficient on Premera's market share is always negative and the T statistics are above 1.5 in 10 of the 16 regressions. The estimated coefficients for primary care claims show no significant relationship to Premera's market share. For the OB/GYN claims, all of the estimated coefficients for the Combined Plan Share and the All Plan Share are negative, and the T statistics are above 1.5 in four of the sixteen cases.

Judging these regression results on an overall basis, the data suggests that the average claims are lower where Premera controls a greater share of the insured patients, yet the statistical reliability of each individual regression is not strong. Nonetheless, the probability that 38 of 42 of the estimated relationships would be negative if each relationship were independent, and the estimates were only randomly different from zero, is far less than one percent. The reliability of

[100] If premium per member accurately picked up all coverage and cost variation across counties, no independent impact for the network area factors would be expected.

the results is, however, weakened since the estimated coefficients on the average premium and the network adjustment factor are frequently negative rather than the expected positive value.

The R squared statistics summarized in Table 4 are never above .40. This indicates that the three independent variables explain only a small percent of the variation in claims amounts across counties. That certainly is not surprising given that medical factors will undoubtedly be the dominant factor leading to higher or lower claims during a particular period.[101]

Implicit Market Power and Pricing Rules

As discussed above, for individual policies, Premera has followed a policy of setting statewide rates. Premera's premiums on individual policies will not, therefore, reflect any cost saving available to Premera from any use of market power to lower costs. Nonetheless, the use of a statewide rate for individual policies may implicitly reflect some exercise of market power in two ways. First, the cost of health care is likely lower in some areas in the state. Under competition, individual policy pricing would be expected to reflect those cost differences, while statewide rates will not.

In addition to not passing on intrinsic cost differences in health care costs across counties, Premera's statewide individual policy pricing may also reflect market power by Premera in not passing on any lower provider prices obtained by the use of its bargaining leverage. Table 3 above shows the reality of this implicit exercise of market power in pricing. [

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I have concluded that at this time Premera does apply the substance and spirit of the OIC rules concerning geographical variations in the small group rates.

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As discussed, the OIC does not "regulate" the pricing of large group plans. Hence any market power that Premera is able to exercise in the provider market need not be passed-on in lower premiums. [

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While I did not find any overall relationship between Premera market dominance and average premium levels as measured by revenue per member, I did attempt to indirectly address whether the margins or administrative costs components of the standard large group rates are at competitive or above competitive levels.[102] An indication of the extent to which the Large Plan Rating Formula yields competitive rates can be measured by examining the situations in which significant Underwriter Adjustments are granted in seeking new business. Above competitive standard rates are indicated if the data show that adjustments are typically made for contracts in the competitive Seattle metro area and Western Washington area but are rare in the less competitive Eastern Washington area.

[

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[102] First of all the procedures for determining these components are very complex and dense. In addition, I do not know how I would identify what is a competitive level of these costs.

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CONCLUSION

The conversion of Premera to a for-profit company will not impact the structure of the market in the insurance market, either on the selling side or on the buying side. Whatever market power Premera may have prior to the conversion will be the same market power that it will have after the conversion. However, under its current operation as a not-for-profit insurer, Premera may not have had the incentive to fully exploit any market power. Hence, the competitive questions faced in trying to assess the likely impact of the conversion on the prices paid by insurers and the prices received by providers are sequential. First, does Premera have any market power in either the sale of insurance or the purchase of health care services? If the answer to this question is no, then the

[103] See 0036113-114.[

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conversion will have no competitive impact. However, if Premera has market power, then the next question is whether Premera has fully exploited its market power. If the answer to this question is yes, then the conversion will have no competitive impact. Only if Premera has market power and will continue to have market power, and only if that market power has not been fully exploited can the conversion impact prices and competition.

I have found evidence that Premera has some market power both in selling insurance and in purchasing providers' services. However, any such market power is limited to Eastern Washington. The evidence that Premera has some market power in selling insurance in Eastern Washington includes Premera's high market shares and the presence of some barriers to entry and expansion by competitors. The evidence also includes Premera's own projections as to cost and pricing and their historical adjustments to formulae rate increases which indicates some control and future expected control over prices and reimbursements. However, the exercise of Premera's market power is constrained by the OIC rate setting rules concerning variation in premiums by area and also by competitive alternatives to Washington registered insurers available to large groups.

The evidence that Premera has some market power in purchasing health care services in Eastern Washington also includes the high Premera market shares and presence of some barriers to entry. [

PROPRIETARY MATERIAL REDACTED

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It is far more difficult to assess whether Premera's market power has been fully exploited. It is clear that Premera has lost and gained business to and from competitors in Eastern Washington. If Premera had not fully exploited any market power in Eastern Washington, I would expect its business to be far more stable there than in Western Washington. I am aware of no such evidence. It is

also clear that Premera has faced a number of situations in which Eastern Washington providers balked at Premera's reimbursement levels necessitating upward adjustments.[104] In addition, according to knowledgeable parties interviewed, the reimbursement rates in Washington are generally at levels that make recruitment of more physicians difficult, and this appears to be equally true in Eastern Washington as in Western Washington. These facts certainly suggest that whatever limited market power is possessed by Premera, that Premera has substantially exploited that power.

Nonetheless, there are likely some unexploited opportunities to raise premiums and lower reimbursements. [

PROPRIETARY MATERIAL REDACTED

] When Premera is converted to for-profit it is expected that the market pressures to fully exploit pricing opportunities will be greater than under its current not-for-profit organization. Hence it is likely that some premiums in some areas will likely increase and some reimbursements to some providers will decrease.

[104] This is based on confidential information.

TABLE 1A

Market Shares of 5 Largest Insurers - Individual Plans

COUNTY	Premera	Regence	Group Health	Kaiser	KPS
ADAMS	98.7%	0.6%	0.6%	0.0%	0.0%
ASOTIN	91.3%	8.7%	0.0%	0.0%	0.0%
BENTON	95.8%	0.7%	3.4%	0.0%	0.1%
CHELAN	97.6%	1.2%	1.1%	0.0%	0.1%
COLUMBIA	33.4%	62.3%	4.2%	0.0%	0.0%
DOUGLAS	99.5%	0.5%	0.0%	0.0%	0.0%
FERRY	97.3%	1.0%	1.6%	0.0%	0.0%
FRANKLIN	96.2%	0.9%	2.9%	0.0%	0.0%
GARFIELD	81.5%	18.5%	0.0%	0.0%	0.0%
GRANT	97.8%	1.2%	0.9%	0.0%	0.0%
KITTITAS	88.8%	4.5%	6.2%	0.0%	0.0%
KLICKITAT	61.9%	37.9%	0.2%	0.0%	0.0%
LINCOLN	97.6%	0.0%	2.4%	0.0%	0.0%
OKANOGAN	97.7%	1.5%	0.5%	0.0%	0.3%
PEND ORIELLE	94.2%	0.0%	5.8%	0.0%	0.0%
SPOKANE	84.1%	0.7%	15.2%	0.0%	0.0%
STEVENS	98.4%	0.3%	1.1%	0.0%	0.0%
WALLA WALLA	30.9%	68.1%	1.0%	0.0%	0.0%
WHITMAN	91.0%	1.3%	7.7%	0.0%	0.0%
YAKIMA	48.4%	49.3%	2.2%	0.0%	0.0%
TOTAL E WA	81.1%	13.0%	5.8%	0.0%	0.0%
CLALLAM	26.3%	65.1%	2.0%	0.0%	6.4%
CLARK	8.1%	16.7%	0.0%	75.2%	0.0%
COWLITZ	15.1%	30.2%	0.1%	54.6%	0.0%
GRAYS HARBOR	41.1%	54.1%	4.5%	0.0%	0.3%
ISLAND	38.9%	41.5%	19.4%	0.0%	0.0%
JEFFERSON	21.2%	20.0%	2.6%	0.0%	55.9%
KING	40.5%	40.8%	18.0%	0.0%	0.1%
KITSAP	19.2%	19.5%	16.8%	0.0%	43.8%
LEWIS	36.1%	51.5%	5.5%	6.6%	0.4%
MASON	31.9%	23.3%	15.0%	0.0%	29.8%
PACIFIC	57.7%	42.0%	0.3%	0.0%	0.0%
PIERCE	26.2%	66.6%	7.0%	0.0%	0.1%
SAN JUAN	34.9%	45.9%	19.2%	0.0%	0.0%
SKAGIT	26.8%	52.5%	20.6%	0.0%	0.0%
SKAMANIA	25.0%	18.2%	0.0%	56.8%	0.0%
SNOHOMISH	40.5%	44.4%	14.6%	0.0%	0.1%
THURSTON	39.1%	35.1%	23.6%	0.0%	2.1%
WAHKIAKUM	24.9%	41.5%	0.0%	33.7%	0.0%
WHATCOM	32.7%	26.8%	40.4%	0.0%	0.2%
TOTAL W WA	32.8%	40.4%	14.1%	9.5%	2.7%
TOTAL	38.8%	37.0%	13.2%	8.3%	2.4%

TABLE 1B

Market Shares of 5 Largest Insurers - Small Group Plans

COUNTY	Premera	Regence	Group Health	Aetna	Kaiser
ADAMS	95.3%	4.6%	0.1%	0.0%	0.0%
ASOTIN	93.3%	5.1%	1.6%	0.0%	0.0%
BENTON	92.3%	6.3%	1.3%	0.0%	0.0%
CHELAN	92.4%	7.4%	0.1%	0.0%	0.0%
COLUMBIA	15.7%	84.3%	0.1%	0.0%	0.0%
DOUGLAS	88.4%	11.5%	0.1%	0.0%	0.0%
FERRY	95.1%	4.7%	0.3%	0.0%	0.0%
FRANKLIN	94.6%	4.6%	0.9%	0.0%	0.0%
GARFIELD	93.3%	4.4%	2.0%	0.3%	0.0%
GRANT	97.9%	2.0%	0.1%	0.0%	0.0%
KITTITAS	92.9%	4.3%	2.7%	0.1%	0.0%
KLICKITAT	89.4%	10.6%	0.0%	0.0%	0.0%
LINCOLN	98.4%	1.2%	0.4%	0.0%	0.0%
OKANOGAN	98.0%	1.9%	0.1%	0.0%	0.0%
PEND ORIELLE	94.8%	2.5%	2.7%	0.0%	0.0%
SPOKANE	89.1%	7.5%	3.2%	0.0%	0.0%
STEVENS	96.3%	2.5%	1.1%	0.0%	0.0%
WALLA WALLA	24.1%	74.2%	0.9%	0.8%	0.0%
WHITMAN	89.4%	8.2%	1.9%	0.0%	0.0%
YAKIMA	80.9%	16.8%	2.1%	0.0%	0.0%
TOTAL E WA	87.5%	10.5%	1.9%	0.0%	0.0%
CLALLAM	22.7%	52.1%	0.3%	12.9%	0.0%
CLARK	7.3%	2.3%	0.1%	0.1%	55.4%
COWLITZ	9.4%	27.3%	0.0%	0.1%	53.9%
GRAYS HARBOR	33.0%	62.9%	1.5%	1.2%	0.0%
ISLAND	15.9%	73.4%	9.8%	0.9%	0.0%
JEFFERSON	9.9%	18.6%	1.4%	0.4%	0.0%
KING	31.4%	55.3%	6.3%	6.5%	0.0%
KITSAP	18.5%	24.3%	4.5%	4.2%	0.0%
LEWIS	24.0%	31.7%	1.2%	37.1%	5.0%
MASON	29.8%	20.9%	7.9%	3.5%	0.0%
PACIFIC	40.9%	51.3%	0.1%	0.1%	0.0%
PIERCE	26.8%	63.4%	3.6%	5.2%	0.0%
SAN JUAN	7.1%	85.9%	6.8%	0.0%	0.0%
SKAGIT	10.3%	72.2%	16.5%	0.8%	0.0%
SKAMANIA	53.5%	18.6%	0.0%	0.0%	11.5%
SNOHOMISH	33.4%	55.1%	6.0%	5.3%	0.0%
THURSTON	38.4%	38.4%	6.5%	9.9%	0.0%
WAHKIAKUM	5.7%	53.3%	0.0%	0.0%	25.0%
WHATCOM	8.6%	54.8%	36.4%	0.1%	0.0%
TOTAL W WA	26.3%	50.8%	7.1%	5.4%	4.5%
TOTAL	43.4%	39.3%	6.0%	3.9%	3.2%

TABLE 1C

Market Shares of 5 Largest Insurers - Large Group Plans

COUNTY	Premera	Regence	Group Health	First Choice	Kaiser
ADAMS	85.3%	8.7%	2.5%	0.0%	0.0%
ASOTIN	65.8%	28.0%	1.6%	0.0%	0.0%
BENTON	59.9%	4.3%	34.6%	0.0%	0.0%
CHELAN	90.8%	7.5%	0.4%	0.0%	0.0%
COLUMBIA	53.1%	26.7%	16.0%	0.0%	0.0%
DOUGLAS	88.1%	10.1%	0.1%	0.0%	0.0%
FERRY	91.6%	4.6%	1.1%	0.7%	0.0%
FRANKLIN	62.9%	6.1%	28.9%	0.1%	0.0%
GARFIELD	75.5%	22.0%	1.5%	0.0%	0.0%
GRANT	90.0%	7.6%	0.6%	0.1%	0.0%
KITTITAS	60.0%	10.4%	25.5%	0.6%	0.0%
KLICKITAT	59.2%	36.0%	0.5%	0.1%	0.0%
LINCOLN	82.3%	7.5%	7.2%	0.8%	0.0%
OKANOGAN	91.4%	6.4%	0.7%	0.0%	0.0%
PEND ORIELLE	77.2%	4.9%	13.2%	3.0%	0.0%
SPOKANE	58.8%	8.4%	29.0%	2.5%	0.0%
STEVENS	63.0%	8.0%	18.9%	5.5%	0.0%
WALLA WALLA	56.6%	21.0%	16.1%	0.1%	0.0%
WHITMAN	71.2%	4.7%	19.2%	0.2%	0.0%
YAKIMA	38.7%	36.3%	22.7%	0.0%	0.0%
TOTAL E WA	62.6%	11.9%	22.3%	1.2%	0.0%
CLALLAM	64.4%	23.7%	1.5%	0.1%	0.0%
CLARK	14.1%	4.7%	0.2%	0.0%	59.0%
COWLITZ	12.1%	14.8%	0.2%	0.0%	59.5%
GRAYS HARBOR	62.9%	25.6%	5.8%	0.6%	0.0%
ISLAND	23.1%	36.6%	35.5%	3.5%	0.0%
JEFFERSON	28.9%	23.6%	12.6%	0.3%	0.0%
KING	28.4%	31.8%	25.8%	5.2%	0.0%
KITSAP	22.0%	12.9%	38.5%	0.6%	0.0%
LEWIS	55.0%	21.4%	11.0%	0.7%	3.4%
MASON	26.5%	14.4%	38.0%	1.3%	0.0%
PACIFIC	70.7%	24.5%	1.3%	0.0%	0.0%
PIERCE	27.2%	41.2%	20.4%	4.7%	0.0%
SAN JUAN	10.6%	66.4%	21.2%	0.5%	0.0%
SKAGIT	19.9%	51.1%	27.3%	0.3%	0.0%
SKAMANIA	33.6%	33.7%	0.0%	0.0%	26.2%
SNOHOMISH	27.4%	39.9%	19.8%	6.6%	0.0%
THURSTON	40.7%	17.2%	31.3%	2.0%	0.0%
WAHKIAKUM	23.7%	41.1%	0.6%	0.0%	19.4%
WHATCOM	13.6%	47.9%	37.6%	0.0%	0.0%
TOTAL W WA	27.4%	31.7%	23.4%	4.0%	4.1%
TOTAL	33.8%	27.7%	23.8%	3.4%	3.3%

TABLE 1D

Market Shares of 5 Largest Insurers - Combined Total

COUNTY	Premera	Regence	Group Health	Kaiser	Aetna
ADAMS	90.2%	6.5%	1.4%	0.0%	0.0%
ASOTIN	74.7%	20.6%	1.5%	0.0%	0.0%
BENTON	66.6%	4.6%	27.9%	0.0%	0.0%
CHELAN	91.5%	7.1%	0.4%	0.0%	0.0%
COLUMBIA	41.2%	45.5%	10.6%	0.0%	1.9%
DOUGLAS	88.6%	10.0%	0.1%	0.0%	0.0%
FERRY	92.8%	4.4%	1.0%	0.0%	0.0%
FRANKLIN	72.7%	5.5%	20.4%	0.0%	0.0%
GARFIELD	79.3%	18.3%	1.5%	0.0%	0.1%
GRANT	92.6%	5.7%	0.5%	0.0%	0.0%
KITTITAS	72.1%	8.1%	17.2%	0.0%	0.2%
KLICKITAT	67.5%	29.6%	0.3%	0.0%	0.0%
LINCOLN	88.5%	5.0%	4.7%	0.0%	0.0%
OKANOGAN	93.0%	5.3%	0.6%	0.0%	0.1%
PEND ORIELLE	80.6%	4.2%	11.3%	0.0%	0.0%
SPOKANE	66.1%	8.0%	23.0%	0.0%	0.0%
STEVENS	72.6%	6.3%	13.9%	0.0%	0.0%
WALLA WALLA	48.9%	33.8%	12.3%	0.0%	4.0%
WHITMAN	77.5%	5.4%	13.7%	0.0%	0.0%
YAKIMA	48.9%	32.4%	17.0%	0.0%	0.0%
TOTAL E WA	68.9%	11.7%	17.0%	0.0%	0.2%
CLALLAM	51.7%	34.6%	1.4%	0.0%	3.5%
CLARK	12.0%	6.5%	0.1%	61.3%	0.0%
COWLITZ	11.9%	17.3%	0.1%	58.4%	0.0%
GRAYS HARBOR	56.3%	33.9%	5.0%	0.0%	0.5%
ISLAND	23.5%	42.1%	30.5%	0.0%	0.5%
JEFFERSON	23.2%	21.8%	8.2%	0.0%	0.4%
KING	29.9%	35.9%	22.4%	0.0%	5.7%
KITSAP	21.5%	14.4%	34.1%	0.0%	2.3%
LEWIS	47.1%	26.0%	8.5%	4.0%	9.9%
MASON	27.3%	15.7%	32.8%	0.0%	1.2%
PACIFIC	64.1%	31.1%	1.0%	0.0%	0.0%
PIERCE	27.1%	45.7%	17.4%	0.0%	3.5%
SAN JUAN	15.8%	66.2%	17.0%	0.0%	0.0%
SKAGIT	18.9%	54.6%	25.1%	0.0%	0.3%
SKAMANIA	35.6%	29.3%	0.0%	28.0%	0.0%
SNOHOMISH	28.9%	42.2%	17.7%	0.0%	4.3%
THURSTON	40.3%	20.7%	28.0%	0.0%	2.9%
WAHKIAKUM	21.0%	43.0%	0.4%	21.9%	0.0%
WHATCOM	13.8%	47.9%	37.5%	0.0%	0.0%
TOTAL W WA	27.6%	35.1%	20.4%	4.6%	3.9%
TOTAL	35.9%	30.4%	19.7%	3.7%	3.1%

TABLE 2

Premera Shares

COUNTY	% of Insureds All Plans	% of Population
ADAMS	47.7%	24.1%
ASOTIN	79.0%	9.5%
BENTON	56.3%	26.1%
CHELAN	75.5%	34.0%
COLUMBIA	31.4%	15.1%
DOUGLAS	68.2%	19.5%
FERRY	71.8%	25.5%
FRANKLIN	46.7%	19.7%
GARFIELD	79.5%	29.2%
GRANT	67.4%	29.9%
KITTITAS	61.7%	24.3%
KLICKITAT	34.0%	9.3%
LINCOLN	74.2%	37.8%
OKANOGAN	64.8%	24.2%
PEND ORIELLE	61.9%	31.2%
SPOKANE	23.1%	26.1%
STEVENS	56.7%	24.3%
WALLA WALLA	16.8%	15.0%
WHITMAN	17.4%	19.0%
YAKIMA	55.2%	12.8%
TOTAL E WA	53.7%	22.8%
CLALLAM	37.6%	13.1%
CLARK	11.8%	2.7%
COWLITZ	10.5%	5.0%
GRAYS HARBOR	39.2%	14.2%
ISLAND	20.0%	8.9%
JEFFERSON	17.5%	7.4%
KING	26.0%	13.2%
KITSAP	17.3%	8.8%
LEWIS	29.3%	12.0%
MASON	16.6%	8.2%
PACIFIC	0.0%	19.5%
PIERCE	67.2%	10.7%
SAN JUAN	22.8%	6.0%
SKAGIT	11.2%	8.0%
SKAMANIA	12.9%	4.9%
SNOHOMISH	23.5%	12.0%
THURSTON	60.7%	12.3%
WAHKIAKUM	25.0%	6.0%
WHATCOM	35.1%	9.1%
TOTAL W WA	24.0%	11.0%
TOTAL	29.2%	6.8%

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Appendix to Report of Keith Leffler, Review of Premera Proposed Conversion

1. MARKET SHARES

Market Shares were calculated for the following categories:

- Individual Groups
- Small Groups
- Large Groups
- Combined Total
- All Total

INDIVIDUAL GROUPS were compiled using individual and conversion plan data. Table A-1 shows specifically which data were included in the Individual category.

SMALL GROUPS were compiled using small group and 1-50 plan data. Table A-2 shows specifically which data were included in the Small Group category.

LARGE GROUPS were compiled using large group, mega group, 51-99, 100+, Negotiated, PPO and POS, and Other plan data. Table A-3 shows specifically which data were included in the Large Group category.

COMBINED TOTAL is the sum of the above Individual, Small, and Large Groups.

ALL TOTAL includes governmental and self-funded categories that were eliminated from the above groups. ALL TOTAL is made up of all the OIC data obtained. Categories are: Small, Large, Mega, Individual, Negotiated, Conversion, ASC, Medicare, Basic Health, PEBB, FEP, PPO and POS, and Other.

OIC Form B membership data (2001) were used to calculate Market Shares with the exception of Cigna for which 2002 data were used.

OIC data were obtained from the provider companies except where noted by "OIC web file" in the FILE column of the above tables. In these cases, the data were obtained directly from the OIC web site.

The following notes explain any data adjustments or inconsistencies:

a.. Premera: Total Enrollees in Large Group does not equal Females + Males because file "FEP BC" only shows data by monthly total and not by gender.

b. Premera: files TRAD Premera LifeWise and PPO Premera LifeWise data begin in June.

c. Group Health: Total Enrollees does not equal F+M. Every GH file errs in July where the Females + Males do not add up to the Total shown for that month. I have adjusted the TOTALS for GH (not monthly totals) to equal Total F + Total M.

d. Cigna, Molina and UMP data were obtained directly.

2. REGRESSIONS

Revenue per Member and Claims data used for the regressions were obtained directly from Premera.

Monthly REVENUE PER MEMBER was calculated using only MATCHING Revenue and Member lines of business for each month.
The SUM of the matching revenues was divided by the SUM of the matching members.
Lines of business that did not match up were eliminated from the data as were all "Other" county data.

CLAIMS data for Out-Patient, Primary Care, and Ob-Gyn were calculated by simply summing the data by month.

County Data were eliminated from the regressions based upon the following parameters:

INDIVIDUAL 2001	
OUTPATIENT	- any county with less than 70 claims
PRIMARY CARE	- any county with less than 125 claims
OB-GYN	- any county with less than 50 claims
INDIVIDUAL 2002	- any county with less than 400 members
OUTPATIENT	- any county with less than 70 claims
PRIMARY CARE	- any county with less than 125 claims
OB-GYN	- any county with less than 100 claims
SMALL GROUP 2001	- any county with less than 2000 members
OUTPATIENT	- any county with less than 55 claims
PRIMARY CARE	- any county with less than or equal to 30 claims
OB-GYN	- any county with less than 50 claims
SMALL GROUP 2002	- any county with les than 1500 members
OUTPATIENT	- any county with less than 50 claims
PRIMARY CARE	- any county with less than 30 claims
OB-GYN	- any county with less than 50 claims
LARGE GROUP 2001	- any county with less than 4000 members
OUTPATIENT	- any county with less than 450 claims
PRIMARY CARE	- any county with less than 325 claims
OB-GYN	- any county with less than 305 claims

LARGE GROUPS 2002	- any county with less than 4000 members
OUTPATIENT	- any county with less than 775 claims
PRIMARY CARE	- any county with less than 325 claims
OB-GYN	- any county with less than 450 claims

COMBINED TOTAL 2001	- any county with less than 10000 members
OUTPATIENT	- any county with less than 1200 claims
PRIMARY CARE	- any county with less than 1000 claims
OB-GYN	- any county with less than 500 claims

COMBINED TOTAL 2002	- any county with less than 10000 members
OUTPATIENT	- any county with less than 1200 claims
PRIMARY CARE	- any county with less than 750 claims
OB-GYN	- any county with less than 725 claims

Additionally any data that appeared suspect with extreme high or low Revenue per Member (<270 or >83) were eliminated. Tables A4 through A7 show the claims per category and the eliminated counties. An "x" indicates that county did not meet the above criteria while as "S" indicates elimination due to suspect data.

APPENDIX --TABLE A-1

DATA USED FOR INDIVIDUAL GROUP CATEGORY

PROVIDER	FILE ID (if multiple)	SHEET (if multiple in file)	CATEGORY/LOB
Aetna		Indiv	Individual
Aetna		Conv - HMO	Conversion
First Choice		Conversion - MNC	Conversion
Group Health	GHC 10		Individual
Group Health	GHC 15		Individual
Group Health	GHC 16		Individual
Group Health	GHC 32		Individual
Group Health	GHC 33		Individual
Group Health	GHC 34		Individual
Group Health	OPT 09		Conversion
Group Health	OPT 15		Conversion
Group Health	OPT 16		Conversion
Group Health	OPTID 03		Conversion
Group Health	ALT 09		Conversion
Group Health	ALT 13		Conversion
Group Health	ALT 14		Conversion
Group Health	GHC 17		Conversion
Group Health	GHC 29		Conversion
Group Health	GHC 30		Conversion
KPS		Individual	Individual
KPS		Conversion - MNC	Conversion
Kaiser	OIC web file		Conversion
Premera		PPO Individual WA	Individual
Premera		Trad Individual WA	Individual
Premera		BS Individual Mngd Care	Individual
Premera		PPO Premera LifeWise Indiv	Individual
Premera		TRAD Premera LifeWise Indiv	Individual
Regence	OIC	Regence Northwest Health	PPO/Individual
Regence	OIC	Regence Northwest Health	Traditional Individual
Regence	OIC	RegenceCare	RegenceCare/Individual
Regence	OIC	Regence BlueShield	POS/Individual
Regence	OIC	Regence BlueShield	PPO/Individual
Regence	OIC	Regence BlueShield	Traditional/Individual
Regence	BlueCross BlueShield of Oregon	Form B BCBSO CHEC	Individual
Regence	BlueCross BlueShield of Oregon	Form B BCBSO Preferred CHEC	Individual
Regence	BlueCross BlueShield of Oregon	FormB Conversion	Conversion
Regence	OIC	Regence BlueShield	PPO/Conversion
Regence	OIC	Regence BlueShield	Traditional/Conversion

TABLE A-2

DATA USED FOR SMALL GROUP CATEGORY

PROVIDER	FILE ID (if multiple)	SHEET (if multiple in file)	CATEGORY/LOB
Aetna		SG QPOS - FI	Small Group
First Choice		Small - POS	Small Group
First Choice		Small - MNC	Small Group
First Choice		Small - OPT	Small Group
Group Health	GHC 01		Small Group
Group Health	GHC 02		Small Group
Group Health	GHC 03		Small Group
Group Health	GHC 04		Small Group
Group Health	GHC 05		Small Group
Group Health	GHC 06		Small Group
Group Health	OPT 02		Small Group
Group Health	OPT 03		Small Group
Group Health	OPT 04		Small Group
Group Health	OPT 05		Small Group
Group Health	OPT 06		Small Group
Group Health	OPTID 02		Small Group
Group Health	ALT 01		Small Group
Group Health	ALT 02		Small Group
Group Health	ALT 03		Small Group
Group Health	ALT 04		Small Group
Group Health	ALT 05		Small Group
Group Health	ALT 06		Small Group
Kaiser	OIC web file		Small Group
KPS		Small Group	Small Group
Premera		PPO CR 1-50 PPO W WA	Small Group
Premera		TRAD CR 1-50 PPO W WA	Small Group
Premera		PPO CR 1-50 PPO E WA	Small Group
Premera		TRAD CR 1-50 PPO E WA	Small Group
Premera		CR 1-50 HMO E WA	Small Group
Providence	a	Prov Option Sm Grp	Small Group
Providence	a	Prov Val Option Sm Grp	Small Group
Providence	e	Amisys Model Plan	Small Group
Providence	e	Amisys Compr Con Mbrs	Small Group
Providence	e	Amisys Major Con Mbrs	Small Group
Providence	e	Disc Model Plan Mbrs	Small Group
Providence	f	Disc Sg Grp 01	Small Group
Providence	f	Disc Sg Grp 03	Small Group
Regence	OIC	Regence Northwest Health	PPO/Small Group
Regence	OIC	Regence Care	RegenceCare/Small Group
Regence	OIC	Regence BlueShield	POS/Small Group
Regence	OIC	Regence BlueShield	PPO/Small Group
Regence	OIC	Regence BlueShield	Traditional/Small Group

TABLE A-3

DATA USED FOR LARGE GROUP CATEGORY

PROVIDER	FILE ID (if multiple)	SHEET (if multiple in file)	CATEGORY/LOB
Aetna		LG QPOS - FI	Large Group
Aetna		PEBB	PEBB
Alta		Sheet 1	PPO/POS
Cigna		GPPO_BY_COUNTY	Large Group
Cigna		PPO_BY_COUNTY	
Community		PEBB 3000-00158	PEBB
First Choice		Large - POS	Large Group
First Choice		Large - MNC	Large Group
First Choice		Large - OPT	Large Group
First Choice		Large - CPO	Large Group
Great West		Sheet 1	PPO/POS
Group Health	OPT 07		Large Group
Group Health	OPT 08		Large Group
Group Health	OPT 19		Large Group
Group Health	OPT 20		Large Group
Group Health	OPTID 01		Large Group
Group Health	ALT 07		Large Group
Group Health	ALT 08		Large Group
Group Health	GHC 07		Large Group
Group Health	GHC 37		Large Group
Group Health	GHC 38		Large Group
Group Health	OPT 14		Negotiated
Group Health	OPT 18		Negotiated
Group Health	ALT 11		Negotiated
Group Health	ALT 12		Negotiated
Group Health	ALT 18		Negotiated
Group Health	ALT 19		Negotiated
Group Health	ALT 20		Negotiated
Group Health	ALT 21		Negotiated
Group Health	ALT 22		Negotiated
Group Health	ALT 23		Negotiated
Group Health	GHC 24		Negotiated
Kaiser	OIC web file		Large Group

KPS KPS		Large Other - FEP	Large Group FEP
One Health	OIC web file		Other
PacifiCare		2001	Secure
Premera		PPO CR 51-99 PPO W WA	Large Group
Premera		TRAD CR 51-99 PPO W WA	Large Group
Premera		PPO CR 51-99 PPO E WA	Large Group
Premera		TRAD CR 51-99 PPO E WA	Large Group
Premera		CR 51-99 POS E WA	Large Group
Premera		PPO ASSOCIATIONS	Large Group
Premera		NATIONAL ACCOUNTS BS	Large Group
Premera		PPO WEA	Large Group
Premera		PPO 100+ MPP W WA	Large Group
Premera		PPO 100+ RETENTION W WA	Large Group
Premera		TRAD 100+ RETENTION W WA	Large Group
Premera		TRAD 100+ MPP W WA	Large Group
Premera		PPO 100+ ReETENTION E WA	Large Group
Premera		TRAD 100+ MPP E WA	Large Group
Premera		100+ HMO E WA	Large Group
Premera		HealthPlus (PEBB)	PEBB
Premera		FEP BC	FEP
Premera		HealthPlus (NoPEBB NoFEP)	Large Group
Premera		HealthPlus (FEP)	FEP
Providence	a	Prov Option Lg Grp	Large Group
Providence	a	Prov Val Otp Lg Grp	Large Group
Providence	f	Disc Lg Grp 01	Large Group
Providence	f	Disc Lg Grp 03	Large Group
Regence	OIC	RegenceCare	RegenceCare/Other
Regence	OIC	Regence BlueShield	PPO/Other
Regence	OIC	Regence Northwest Health	PPO/Large Group
Regence	OIC	Regence Northwest Health	Traditional/Large Group
Regence	OIC	RegenceCare	RegenceCare/Large Group
Regence	OIC	Regence BlueShield	POS/Large Group
Regence	OIC	Regence BlueShield	PPO/Large Group
Regence	OIC	Regence BlueShield	Traditional/Large Group
United Medical		original	PEBB
United Wisconsin	OIC web file		Other

PROPRIETARY MATERIAL REDACTED

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